Strong Roots Counseling, Inc
Consent for Release of Information

Name:_____ Date of birth _____

Address:_____

Telephone :_____

I authorize Strong Roots Counseling, Inc to (check all that apply)

___ disclose information

___ obtain information

___ exchange information

Name and address of individual or agency to whom the release & information will be sent:

_____

_____

Telephone :_____ Fax:_____

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For the purpose of:

____payment ____coordination of care ___continuity of care ___other:_____

Please release the following information:

___clinical assessment, treatment plan and progress notes

___treatment summary

___other:_____

_____

I understand that this release will automatically expire one year from this date. This release may be revoked in writing at any time. Cancellation becomes effective upon receipt of written notice. I understand that a photocopy of the release shall be considered equivalent to the signed original. I

understand access to this information will be limited to persons in the office whose work assignment reasonably requires access and that disclosure of this information to parties, other than those stated above, cannot occur without my express written consent, unless required by law.

Signature:_____ Date:_____

Signature of parent, representative or legal guardian if patient is a dependent minor

_____ Date:_____

SPECIFIC AUTHORIZATIONS

I understand that my records may contain information regarding diagnosis or treatment for drug or alcohol abuse. I give my specific authorization for these records to be released. I also understand that my records may contain information regarding testing, is, or treatment of HIV/AIDS, or of sexually transmitted diseases. I give my specific authorization for these records to be released. I hereby release Strong Roots Counseling, Inc from all legal responsibility that may arise from the release of the medical information hereby authorized. I understand I may revoke and may change any or all parts of this entire release at any time, unless action has already been take as a result of the release, by notifying Strong Roots Counseling, Inc in writing. I understand this release ends automatically upon termination of care.

Signature:_____ Date:_____

Signature of parent, representative or legal guardian if patient is a dependent minor

_____ Date:_____

Witnessed by Strong Roots Counseling, Inc

Signature:_____ Date:_____